ADTC(M) 15/02
Minutes: 13 - 25

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the Area Drugs and Therapeutics Committee held in the Boardroom, JB Russell House on Monday, 20 April 2015 at 2.00 p.m.

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P R E S E N T

Mrs J Watt (in the Chair)

Mrs A Campbell	Mrs L Hillan
Dr G Forrest	Dr J Larkin
Dr R Hardman	Dr J MacKenzie
Mrs A Thompson	Dr S Muir
Dr J Burns	Dr A Taylor
Mr G Gorman	Ms H Lindsay
Dr G McKay	Dr C Harrow

I N A T T E N D A N C E

Miss F Qureshi .....Medicines Information Pharmacist
Miss L Young.....Secretariat Officer

ACTION BY

13. CHAIR'S STATEMENT

The Chair reminded Members that papers and proceedings relating to SMC advice were, in some cases, confidential and should not be disclosed before the relevant embargo dates stated in the agenda.

She also reminded Members that they should make relevant declarations of interest in line with Board policy.

Members were advised not to speak with members of the press on ADTC business but to refer such enquiries to the Board press liaison office.

14. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Dr J Gravil, Dr A Bowman, Dr A Petrie, Dr G Simpson, Dr K McAllister, Mrs Margaret Ryan, Prof. Scott Bryson, Dr Andrew Seaton and Dr A Crighton.

The Committee noted that Prof. Scott Bryson will retire on 30th April 2015. The Committee noted their sincere thanks to Prof. Bryson for his support over the years with ADTC business and Scottish Government medical related issues.

15. MINUTES

The minutes of the meeting of the Area Drugs and Therapeutics Committee held on 16 February 2015 were approved as a correct record.

NOTED

16. MATTERS ARISING

ketoprofen gel

As a result of an appeal to add Ibuprofen gel to the Preferred List, the Committee was asked to consider removing ketoprofen gel from the Preferred List. Ms Qureshi highlighted that ketoprofen gel is not a preferred option for clinicians due to photosensitivity issues. Mr Foot was tasked with reviewing the figures for the Committee. Ms Qureshi informed the Committee that the use of ketoprofen gel is low, with prescribing sitting at 8% over a 3 year period. An increase in cost was noted however this has since reduced.

DECISION:

The Committee agreed to move ketoprofen gel from the Preferred List to the Total Formulary due to its low use and poorer tolerability.

17. FORMULARY AND NEW DRUGS SUB-COMMITTEE
Report on SMC Product Assessments

Dr Forrest gave a brief resume of the SMC reviews and the Formulary and New Drugs Sub-Committee's recommendations.

Members were asked to declare any interests specific or non-specific, personal or non-personal, on any of the drugs being discussed on an individual basis.

One declaration of interest was made.

Major Changes

(a) regorafenib 40mg film-coated tablet (Stivarga®) [1031/15]*[Bayer plc]****[Full Submission][Indication: Treatment of adult patients with unresectable or metastatic gastrointestinal stromal tumors (GIST) who progressed on or are intolerant to prior treatment with imatinib and sunitinib]***

The SMC decision was "Accepted for use within NHS Scotland"

The Committee noted that this product was assessed under the ultra-orphan and end of life process. The advice takes account of a PACE statement and the benefits of a Patient Access Scheme (PAS). Dr Forrest highlighted that small patient numbers are anticipated.

The Committee agreed that this medicine should be added to the Adult Formulary (Total Formulary) pending protocol. It will be restricted to specialist use in accordance with regional protocol, currently in development.

(b) ponatinib 15mg, 45mg film-coated tablets (Iclusig®) [1032/15] [ARIAD pharmaceuticals, Inc.]***[Full Submission][Indication: Chronic phase, accelerated phase, or blast phase chronic myeloid leukaemia (CML) who are resistant to dasatinib or nilotinib; who are intolerant to dasatinib or nilotinib and for whom subsequent treatment with imatinib is not clinically appropriate; or who have the T315I mutation. Philadelphia chromosome positive acute lymphoblastic leukaemia (Ph+ALL) who are resistant to dasatinib; who are intolerant to dasatinib and for whom subsequent treatment with imatinib is not clinically appropriate; or T315I mutation]***

The SMC decision was "Accepted for use within NHS Scotland"

This medicine was assessed under the end of life process for the above indication. The advice

takes account of the views of a PACE meeting. The Committee noted that small patient numbers are predicted.

The Committee agreed that this medicine should be added to the Adult Formulary (Total Formulary) pending protocol, restricted to specialist use in accordance with regional protocol which is currently in development.

(c) sucroferric oxyhydroxide 500mg chewable tablets (Velphoro®)[1035/15] *[Fresenius Medical Care (UK) Ltd.]**[Full Submission][Indication: Control of serum phosphorus levels in adult chronic kidney disease (CKD) patients on haemodialysis (HD) or peritoneal dialysis (PD). It should be used within the context of a multiple therapeutic approach, which could include calcium supplement, 1,25-dihydroxy vitamin D3 or one of its analogues, or calcimimetics to control the development of renal bone disease]***

The SMC decision was "Accepted for use within NHS Scotland"

Dr Forrest highlighted that the Formulary and New Drugs Sub-Committee recommended that this medicine should be restricted to second line use after calcium binders, similar to sevelamer, which is more restrictive than SMC advice. The Committee noted that low uptake is anticipated however clinicians feel it is helpful to have an alternative. Dr Forrest highlighted a slight concern with the packs short expiry date but this was not considered to be a major issue. It was noted that patients should be counselled about the potential for black stools.

The Committee agreed to add this medicine to the Adult Formulary (Total Formulary) restricted to specialist initiation for second-line therapy in adult patients receiving haemodialysis or peritoneal dialysis where a non-calcium phosphate binder is required.

(d) nintedanib 100mg and 150mg soft capsules (Vargatef®) [1027/15] *[Boehringer Ingelheim International GmbH]**[Full Submission][Indication: In combination with docetaxel for the treatment of adult patients with locally advanced, metastatic or locally recurrent non-small cell lung cancer (NSCLC) of adenocarcinoma tumour histology after first-line chemotherapy]***

The SMC decision was "Accepted for use within NHS Scotland"

This product will be used in combination with docetaxel therefore there may be low uptake locally as patients are often considered unfit for this treatment. The Committee noted the modest improvement in survival. The advice took account the views of a PACE meeting and benefits of a Patient Access Scheme (PAS).

The Committee agreed to include this medicine to the Adult Formulary (Total Formulary) pending protocol, restricted to specialist use in accordance with regional protocol which is in development.

(e) ledipasvir/ sofosbuvir, 90mg/400mg, film-coated tablet (Harvoni®) [1030/15] *[Gilead Sciences Ltd]**[Full Submission][Indication: Treatment of chronic hepatitis C (CHC) in adults]***

The SMC decision was "Accepted for restricted use within NHS Scotland"

This treatment option is favoured by clinicians as it is interferon free and for some patients an 8 week course is sufficient. A draft implementation plan for 2015/16 has been developed by the MCN in conjunction with PHPU/PMG which, if approved, will support use of this medicine: however it is expected that use will be more restricted than SMC advice.

The Committee agreed to include this medicine in the Adult Formulary (Total Formulary) restricted to specialist use in adult patients with genotype 1 and 4 chronic hepatitis C, in accordance with local protocol.

(f) apixaban, 2.5mg & 5mg, film-coated tablets (Eliquis®) [1029/15] *[Bristol-Myers Squibb & Pfizer]**[Full Submission][Indication: Treatment of deep vein thrombosis (DVT) and***

pulmonary embolism (PE) and prevention of recurrent DVT and PE in adults]

The SMC decision was "Accepted for use within NHS Scotland"

This advice opens access to NOACs for patients who require long term anticoagulation after DVT/PE. The Committee noted that short term use has already been accepted for rivaroxaban and dabigatran.

A detailed discussion took place around management of dosage changes and supply arrangements.

The committee agreed that it may be helpful to select a preferred NOAC and further advice on that and implementation would be sought from the Thrombosis Committee. Patient information leaflets would also be desirable.

DECISION:

The Committee agreed that apixaban should not be added to Formulary pending a decision about a preferred NOAC and preparation of appropriate supporting paperwork. Once there is further clarity, the NOAC FAQ document should be updated to include the PE and DVT indications.

The Chair will inform Dr Campbell Tait of the decision. **Chair**

(g) idelalisib 100mg and 150mg tablets (Zydelig®) [1026/15][Gilead Sciences Ltd.]***[Full Submission][Indication: In combination with rituximab for the treatment of adult patients with chronic lymphocytic leukaemia (CLL) who have received at least one prior therapy, or as first line treatment in the presence of 17p deletion or TP53 mutation in patients unsuitable for chemo-immunotherapy]***

The SMC decision was "Accepted for restricted use within NHS Scotland"

This medicine is used in combination with rituximab. SMC restricts this product to patients with relapsed CLL who are unsuitable for chemotherapy or treatment naïve patients with 17p deletion or TP53 mutation who are unsuitable for chemo-immunotherapy. The Committee noted that small patient numbers are predicted. The advice takes account of the benefits of a Patient Access Scheme (PAS).

The Committee agreed to include this medicine in the Adult Formulary (Total Formulary) pending protocol and restricted to specialist use in accordance with regional protocol which is in development.

(h) dabrafenib, 50mg and 75mg hard capsules (Tafinlar®)[1023/15]*[GlaxoSmithKline]****[Full Submission][Indication: Monotherapy treatment of adult patients with unresectable or metastatic melanoma with a BRAF V600 mutation]***

The SMC decision was "Accepted for restricted use within NHS Scotland"

This medicine is welcomed by oncologists as an alternative to vemurafenib with a different adverse effect profile. The advice took account of a PACE statement and the benefits of a Patient Access Scheme (PAS).

The Committee agreed to include this medicine in the Adult Formulary (Total Formulary) pending protocol and restricted to specialist use in accordance with regional protocol which is in development

(i) ruxolitinib (as phosphate), 5mg, 15mg, & 20mg tablets (Jakavi®)[867/13] *[Novartis Pharmaceuticals UK Ltd.]****[Full Submission][Indication: Treatment of disease-related splenomegaly or symptoms in adult patients with primary myelofibrosis (also known as chronic idiopathic myelofibrosis), post polycythaemia vera myelofibrosis or post essential***

thrombocythaemia myelofibrosis]

The SMC decision was "Accepted for use within NHS Scotland"

The advice took account of a PACE statement and the benefits of a Patient Access Scheme (PAS). The Committee noted the major impact of this medicine was on improving quality of life. Patient numbers are expected to be higher than those predicted in SMC advice; however this has been included in the financial plan for 2015/16.

The Committee agreed to include this medicine in the Formulary pending protocol. It will be restricted to specialist use in accordance with regional protocol which is in development.

Minor changes

(j) fingolimod, 0.5mg hard capsules (Gilenya®)[1038/15]*[Novartis Pharmaceuticals UK]****[Full Submission] [Indication: As a single disease modifying therapy in highly active relapsing remitting multiple sclerosis (RRMS) for adult patients with high disease activity despite treatment with at least one disease modifying therapy]***

The SMC decision was "Accepted for use within NHS Scotland"

The Committee noted the minor licence change for the above product.
The Committee agreed to include this indication in the Adult Formulary (Total Formulary) restricted to specialist use.

(k) levonorgestrel 13.5mg intrauterine delivery system (Jaydess®)[1036/15] *[Bayer]****[Full Submission][Indication: Contraception for up to 3 years]***

The SMC decision was "Accepted for use within NHS Scotland"

The Committee noted that the above product offers contraception over a 3 year period, compared to 5 years for Mirena. There is interest from clinicians, in particular from the Sandyford Clinic, for this product to be added to the Preferred List. Dr Taylor raised a question in relation to the cost of the product as it will be fitted more frequently. Mrs Campbell informed the Committee that the two products were relatively similar in cost when considered on a per annum basis.The Committee noted that other similar products are expected soon.

The Committee agreed to include this medicine in the Adult Formulary (Total Formulary) for the indication in question.

(l) tacrolimus (as monohydrate) 0.75mg, 1mg and 4mg prolonged-release tablets (Envarsus®)[1041/15]*[Chiesi Ltd]****[Abbreviated Submission][Indication: Prophylaxis of transplant rejection in adult kidney or liver allograft recipients and treatment of allograft rejection resistant to treatment with other immunosuppressive medicinal products in adult patients]***

The SMC decision was "Accepted for use within NHS Scotland"

This medicine needs to be prescribed by brand name due to variation in bioavailability and the Committee noted specialist advice that this would not currently be the preferred brand. ScriptSwitch will be used to highlight the preferred brand within Primary Care.

The Committee agreed to include this medicine in the Adult Formulary (Total Formulary) restricted to specialist initiation.

(m) infliximab, 100mg, powder for concentrate for solution for infusion (Remsima®) [1006/14] *[Celltrion Healthcare Hungary Kft.]****[Full Submission][Indication: Treatment of rheumatoid arthritis in combination with methotrexate (see SMC advice for full details of indication)]***

(n) infliximab, 100mg, powder for concentrate for solution for infusion (Inflectra®)[1007/14]*[Hospira UK Ltd.]****[Full Submission] [Indication: Treatment of rheumatoid arthritis in combination with methotrexate (see SMC advice for full details of indication)]***

The SMC decision was "Accepted for restricted use within NHS Scotland"

A detailed discussion took place around the introduction of biosimilar products including the need to prescribe by brand name. There was general support for selecting just one biosimilar infliximab for use in GGC but it would be difficult to choose one brand over another as there is no experience of using.

Generally, there is local support for using biosimilar infliximab in new patients initially and perhaps switching others at a later stage.

The Committee agreed that a discussion should take place with gastroenterology, rheumatology, dermatology and paediatricians about the possibility of choosing a preferred biosimilar infliximab. An implementation plan should be created. Batch numbers should be recorded.

(o) aclidinium/formoterol fumarate dehydrate 340/12 micrograms inhalation powder (Duaklir Genuair®)[1034/15]*[Almirall / AstraZeneca]****[Full Submission][Indication: Maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD)]***

The SMC decision was "Accepted for use within NHS Scotland"

The Committee noted that this is a new combination maintenance treatment. Following a section review, this product has been highlighted as one of the preferred LABA/LAMA combinations. The Committee noted that there may be significant cost savings.

The Committee agreed to include this medicine in the Adult Formulary (Preferred List).

(p) fosfomycin 40mg/mL powder for solution for intravenous infusion (Fomicyt®)[1033/15] *[Nordic Pharma]****[Abbreviated Submission][Indication: For the treatment of the following infections in adults and children including neonates: Acute osteomyelitis, complicated urinary tract infections, nosocomial lower respiratory tract infections, bacterial meningitis, bacteraemia that occurs in association with, or is suspected to be associated with, any of the infections listed above]***

The SMC decision was "Accepted for restricted use within NHS Scotland"

This medicine will be managed locally as an ALERT antibiotic and used on the recommendation of an infection specialist/microbiologist.

The Committee agreed to include this medicine in the Adult Formulary (Total Formulary) restricted to specialist use.

Not Recommended: the following medicines/indications were all not included in Formulary as not recommended by SMC

(q) cabozantinib 20mg and 80mg hard capsules (Cometriq®)[1022/15] *[Swedish Orphan Biovitrum Ltd.]****[Full Submission][Indication: Treatment of adult patients with progressive, unresectable locally advanced or metastatic medullary thyroid carcinoma]***

Other Formulary Decisions

(r) Trospium chloride

Ms Qureshi advised the Committee that FND has recommended that trospium chloride is moved from the Preferred List to the Total Formulary. This decision follows discussions regarding its low use compared to other agents and takes into account changes in pricing. Dr Taylor suggested that perhaps a review of the whole area is required. Mrs Thompson advised that a Medicines Update Extra will be created which will go into detail of the evidence.

The committee agreed that trospium be moved to the Total Formulary.

(s) Infliximab, adalimumab and golimumab for Ulcerative Colitis

The Committee noted that the NICE MTA supersedes existing SMC advice relating to medicines in this indication. Infliximab, adalimumab and golimumab will now be added to the Total Formulary Use for the treatment of moderately to severely active ulcerative colitis in adults, restricted to those patients whose disease has responded inadequately to conventional therapy, including corticosteroids, mercaptopurine and azathioprine, or who cannot tolerate, or have medical contraindications for such therapies.

ADTC were supportive that a local protocol should be developed.

(2) Colecalciferol preparations

Dr Forrest informed the Committee that in February 2015, SMC advised that they will no longer consider Vitamin D preparations as the minor differences between preparations do not warrant a review. The Formulary and New Drugs Sub-Committee noted this development and has recommended that the Formulary entry would now include only generic colecalciferol; high and low dose Vitamin D will be differentiated in the prescribing notes. The Sub-Committee agreed that 1000 units or less will be classed as low dose and greater than 20,000 units will be classed as high dose. Following previous discussions around the perceived risk associated with InvitaD3 oral ampoule being mistaken for an injectable preparation, the Formulary and New Drugs Sub-Committee agreed for it to remain on the Formulary and restrict its use to when other preparations are not suitable. Dr Forrest noted that Fultium D3 3,200 units will be removed from the Formulary as this strength is considered less cost-effective.

Dr Taylor raised concerns in relation to generic prescribing as a number of different preparations are available. A discussion took place around this and Committee agreed that there would be potential problems prescribing by brand as brands may be available in a range of strengths. The Committee therefore agreed that these preparations should continue to be prescribed generically.
The Committee noted the information provided and that vitamin D products will no longer be assessed by ADTC but will be included to the Formulary unless specifically excluded.

(3) Review Recommendations - Respiratory Inhaler Review

Ms Qureshi summarised the recommendations of a review of the asthma and COPD sections of the Respiratory chapter of the GGC Adult Formulary carried out by the Formulary and Therapeutic Handbook Team alongside the Respiratory MCN Prescribing Subgroup. Ms Qureshi highlighted the following decisions;

- Formoterol to be the first choice single agent LABA
- Salmeterol to be moved to the Total Formulary - this decision is based on flexibility (as Formoterol is available in a number of different devices) and cost
- Tiotropium (Spiriva®) to be retained in the Preferred List (HandiHaler® and Respimat®)
- Aclidinium Eklira Genuair®) to become the other Preferred List single-agent LAMA
- Glycopyrronium bromide (Seebri Breezhaler®) to be removed from the GGC Formulary as this inhaler is less user friendly.
- Aclidinium and formoterol (Duaklir Genuair®) be added to the Preferred List
- Glycopyrronium bromide and indacaterol (Ultibro Breezhaler®) to be removed from the GGC Formulary
- Beclometasone remain as the Preferred List single-agent inhaled corticosteroid - There will

be no change made to corticosteroids as this section reflected current use in practice.

- Beclometasone and formoterol (Fostair® and Fostair NEXTHaler®) remain in the Preferred List. However, the prescribing note for the formulary entry should highlight that the NEXThaler device is not licensed for use in COPD or for the maintenance and reliever use in asthma
- Fluticasone and salmeterol (Seretide 500 Acuhaler®): Only this strength and presentation should remain in the Preferred List. It should be restricted to use in the management of asthma in adults at step 4 or above of the BTS/SIGN guidelines
- Other strengths and presentations of Seretide® will be moved to the Total Formulary

The Committee discussed the recommendations in the report. Concerns were raised in regards to changing patient's inhalers to unfamiliar devices. Dr MacKenzie suggested a more realistic option would be to start with new patients instead of existing patients. Dr Taylor highlighted safety concerns with patients using two similar combination inhalers at the one time. He highlighted that patients can be confused about what inhaler to use and often do not dispose of old inhalers.

The Respiratory MCN has conducted a review of inhaler devices and products and has prepared an inhaler device guide. This had informed the inhaler Formulary section review. The Committee agreed that due to the practicalities of managing the changes and safety issues, a discussion with the Respiratory Prescribing Group would be helpful. A member of the group will be invited to attend the next meeting.

The Committee agreed that due to the complexities identified the Committee will defer from a decision on the Formulary section until the next meeting.

18. SAFER USE OF MEDICINES SUB-COMMITTEE

Six Monthly Report

Professor McKay tabled the Safer Use of Medicines Sub-Committee 6 monthly report to inform the ADTC of the work of the Sub-Committee.

Prof. McKay highlighted the main points that were discussed at the last meeting. The membership of the Sub-Committee currently includes representation from various directorates including ECMS, S&A and RAD. Prof McKay informed the Committee that membership will be discussed at the next meeting to ensure it remains fit for purpose. He went on to highlight the items discussed at the last meeting which included:

- Clinical Pharmacy Triage and Referral

A number of different projects are underway to pilot methods to target the Clinical Pharmacy Service at patients with the greatest need. Criteria have been developed to stratify patients according to risk with the frequency of review of the pharmacy service based on this risk. There are also plans to allow medical and nursing staff to refer specific patients to the pharmacist.

- Hospital in-patient prescription charts

Prof. McKay highlighted that a Framework for development and approval of hospital in-patient prescription charts has been agreed and will be implemented.

- Safer administration of IV fluids

A short life working group has been set up to look at standardising IV fluid charts/adult syringe or infusion pump prescription charts across NHS GGC. An Insulin prescription chart has been finalised to ensure there is standardisation across NHS GGC.

- Policy for Medicines reconciliation in hospital

A policy to define roles and responsibilities has been approved.

- High risk medicines

There is a requirement for further education on the use of Vancomycin prescription charts as concerns have been raised on some sites.

Prof. McKay informed the Committee that the Safer Use of Medicines risk register is in the process of being updated to show the progress in all areas and it will form the basis of an annual review. This will be available for the next meeting.

The Committee acknowledged the 6 monthly report submitted and noted the significant amount of work that is being carried out.

NOTED

19. THERAPEUTICS SUB-COMMITTEE

The Committee noted the Therapeutics Sub-Committee 6 monthly report which highlighted progress with a range of non-medicine related formulary work.

Mr Gorman highlighted to the Committee the work plans that are in place to support prescribing quality in a range of non drug therapeutic areas.

Wound Formularies
Mr Gorman highlighted that there is an improvement in Joint Wound formulary compliance which is now at 51%. There has been minimal change in expenditure, moving downward from £676,800 to £673,000. The Tissue Viability Nurse Team continue to lead Wound Formulary education sessions which function on a drop in style basis.

The Wound Dressings Formulary for compression bandages was ratified by the therapeutics group at the last meeting in April 2015 and included in the GGC prescribing clinical guidelines. There are workshops taking place for DN's to carry out compression therapy. A draft compression hosiery formulary has been circulated for consultation to a wider stakeholder group and could potentially be finalised at the next meeting in May.

Dr Forrest raised a point in relation to ordering and prescribing dressings. At the moment the drop down box within GP prescribing systems does not inform the prescriber how many bandages are in a pack. GPs are expected to order bandages as single units but information on the pack size would be helpful. Mr Gorman advised the Committee he would look into this and advise accordingly.

Mr Gorman updated the Committee on the Core Dressing Initiative. A draft core product list has been agreed which is based on previous choices and is in line with the wound formulary when it is appropriate. There are some issues with stocking issues which are being worked through at the moment.

A brief update was provided on the Stoma Care Formulary/Guidance. The guidance will be ratified by the therapeutics group at the next meeting in May.

The Urology Products Formulary is now included in the GGC prescribing clinical guidelines following approval in November.

Mr Gorman informed the Committee that preferred choices have been agreed for Diabetic needles and lancets and a guidance document has been produced for ratification at the May Therapeutics Group; transition is underway. Dr McKenzie raised a concern regarding preferred choices for lancets as not all lancets will fit all machines. Mr Gorman noted the concern raised, however informed the Committee that this aspect was considered and in the majority of cases no problems were anticipated as although

the lancets could not be guaranteed to fit every device they are generally compatible with most..
Mr Gorman informed the Committee that a number of new Dietetics Formularies/Guidance has been produced. Work has taken place on the Gluten Free Formulary, Oral Nutrition Formularies, Non-IgE Mediated Cow's Milk Allergy Guideline, High Energy/Low Volume Prescribing Guideline and Thickeners.

Work has been carried out with support from Ms Kathrin Greschner, Formulary and Handbook Support Pharmacist, to standardise all of the non drug formularies to provide consistency in access on the GGC Prescribing website.

A new process has been developed to record/report non formulary use of the products within the non drug formularies. The new process will see product appraisal requests in partnership areas being submitted to the therapeutics committee for agreement.

A GGC Non Medical Prescribing (NMP) Conference was held on 4th March 2015. There was an overwhelming response from applicants and the conference was extremely over subscribed. This was recognised as a challenge and alternative methods of delivery and funding for the future as being explored. A quarterly newsletter is circulated by the NMP team to provide updates and information.

A brief update was provided on the PGD Group.

Mr Gorman informed the Committee that he attended the Yellow Card Scheme 50th Anniversary Scientific Conference on 20th March 2015 in Edinburgh. The conference was held to celebrate the success of the scheme while recognising the limitations and to set a road map for the future. Mr Gorman submitted a brief report summarising the main points. The presentations provided on the day are available for delegates to download therefore Mr Gorman has sought authorisation from MHRA to share the presentations with the Committee.

Mr Gorman circulated the draft Yellow Card Roadmap which is out for consultation. He highlighted that if the Committee has any feedback these should be addressed to the email address in the document.

The Committee noted the significant work programme for which the Therapeutics Sub-Committee has responsibility. The increasing number of non-medical prescribers and the importance of reaching them with messages about safe and effective prescribing practice was also emphasised.

NOTED

20. PRESCRIBING INTERFACE SUB-COMMITTEE

Dr Hardman summarised the work undertaken by the Prescribing Interface Sub-Committee during 2014 and provided an update on future work.

The Sub-Committee continue to meet on a quarterly basis. Dr Hardman noted that membership has changed slightly with 2 new GP's joining the Committee in December 2014. The Committee now has 5 GP's as members, one of which is a LMC representative.

The Sub-Committee has approved six Shared Care Protocols for use within NHSGGC, which are available through the Shared Care Protocol pages on StaffNet.

Shared Care Protocols

Mrs Hillan informed the Committee that turnaround is now quicker and strong advice is being provided. A checklist is available on the website which gives an idea of the monitoring involved, in particular blood monitoring.

Dr Hardman highlighted the new Shared Care Protocols under development or pending final approval, which include; Enoxaparin, Voriconazole (currently back with the authors) Linezolid and Denosumab.

Existing Shared Care Protocols that are being reviewed or due to expire include Melatonin, 4 Hepatitis B medicines and Ticagrelor.

Dr Hardman highlighted in his report the need to review a number of historical SCP's that are in existence prior to the creation of the Prescribing Interface Sub-Committee. The priority for inclusion in the 2015/16 workplan includes acamprosate, adult growth hormone and renal transplant medicines.

A link has been created in the Clinical Info section of StaffNet that links directly to the Shared Care Protocol site.

The Committee noted the progress reported and the important work that is being carried out.

NOTED

21. OTHER ADTC SUB-COMMITTEES

Medicines Utilisation Sub-Committee

Nothing specific to report

Communications Sub-Committee

Mrs Thompson informed the Committee that the Corporate Communications Team has approved the use of Social Media e.g. Facebook and Twitter to share messages from the ADTC Communication Subcommittee to promote good prescribing practice. Mrs Thompson will report details of the progress to the Committee as and when they are available.

NOTED

22. HIS CONSULTATIONS

NHS Bio-Similars Prescribing Framework

The Chair informed the Committee that feedback had been received by the Committee which was in the main positive. The feedback has now been submitted. The final version of the Framework is due mid May and then local implementation will take place.

Hepatitis C Medicines Treatment Protocols

A proposed approach to developing national recommendations for ADTC ratification on the place of Hepatitis C medicines in treatment protocols was circulated with the papers. The paper outlines the proposed way forward and seeks views and endorsements from ADTC's. The Committee noted the national recommendations and noted that support and implementation of the recommendations is key to incentivising manufacturers to offer their lowest prices.

ADTC Public Partner Recruitment Resources

The Committee noted an advert and role description circulated with the papers to recruit lay representatives to act as public partners on the Area Drugs and Therapeutic Committee. The Chair informed the Committee that a SLWG will be set up to discuss how best to involve public partners in the work of the GGC ADTC. However, as further guidance is anticipated from Scottish Government and therefore the group has been delayed until this has been received.

23. PRESCRIBING MANAGEMENT GROUP REPORT

The key points and actions from the Prescribing Management Group which took place on 10 February 2015 were circulated to the Committee.

Mrs Campbell informed the Committee that the outcome of a legal challenge from Pfizer on generic prescribing of pregabalin is being awaited. Dr Larkin raised concerns about the stance described in the paper which states that the prescribing management group will "support current ADTC position, namely to do nothing to change current practice and await outcome of legal decision in June '15". The Chair clarified that ADTC has not offered any specific advice on prescribing of pregabalin and any advice related to generic prescribing in general.

The Committee noted the paper submitted by the Prescribing Management Group.

24. ANY OTHER BUSINESS

Mrs Watt informed the Committee that due the limited storage space at the new South Glasgow University Hospital, there are plans that instead of one BNF being supplied to each doctor, one BNF will be made available in each clinical area. Staff will be encouraged to use the App to access a BNF and there are plans to explore addition of the BNF icon to every desktop. It was agreed to test this model of BNF distribution in the new hospital and give consideration whether to reduce distribution of paper copies on the other acute sites next year.

25. DATE OF NEXT MEETING

Monday 8 June 2015, 2:00pm, Board Room, JB Russell House, Gartnavel Royal Hospital